

the main operation is done one month later. The operation consists in attaining apposition and retaining apposition without possibility of movement between the ends. The method of actually attaining apposition will depend upon the bone and the condition of the bone ends. The methods employed are the "slot" or "dovetailing" method, the "step" method, the sliding bone-graft, and bone transplantation, the slot being filled with an accurately fitting piece of bone cut from some other bone, usually the tibia. This last is the most successful type of bone transplantation. Speed is of importance as bone dries very quickly after exposure. The uncovered parts are bathed with warm saline. In every case, the ends are securely bound together by drilling holes and using thick thirty-day catgut. The whole limb is put up in plaster, paying particular attention to fixation of the joint above and below. A radiogram, taken through the plaster may be taken in a day or so to see that all is well. After bone grafting or transplantation it is wise not to remove the plaster before the end of three months and a protective splint used for further period. The length of time of non-union, even a period of years, should not deter one from operating with a reasonable certainty of a good result.

**The Indications for Cholecystectomy.**—MONSARRAT (*Brit. Med. Jour.*, 1921, p. 371), says that the problem in the treatment of cholecystitis whether associated with gallstones or not is to arrest infection and obviate its recurrence. The test of successful operation for cholecystitis, is whether the infection of the bile channels clears up, the liver function returns to normal with no recurrent symptoms from inflammatory reaction or adhesions in the operation area. It has been the author's experience that a considerable proportion of cases of cholecystitis treated by drainage fail to pass this test, for ill health is suffered referable to the persistence of the gall-bladder as a centre of infection. Chronic cholangitis with chronic pancreatitis, recurrent attacks of pain and tenderness in neighborhood of the wound, gastric distention, spasm and vomiting due to the angulation of the pylorus and duodenum by adhesions are resulting conditions. For these reasons, it seems advisable to remove a gall-bladder which has been attacked by cholecystitis of any type, because patients who have had the gall-bladder removed do not suffer any demonstrable disadvantage from its absence, while in calculous cholecystitis they are relieved of the double risk of reformation of stones and persistence of bile-duct inflammation. In cases of cholecystitis without calculi, patients are relieved of a diverticulum which would in all probability prove to be the source of a recrudescence of their intoxication. Granted that cholecystectomy is a cleaner performance and not a more serious operative risk than cholecystostomy—that the gall-bladder is of no particular functional value in the human subject, that it is, moreover, the nidus of persistent infections in the biliary channels—then argument for cholecystectomy as the normal operation in cholecystitis is overwhelming.

**Treatment of Syphilis.**—FELDMAN (*Amer. Jour. Syphilis*, 1921, v, 268) says that the results obtained in primary lues by treating the patient before his blood becomes positive is not much better than when treatment is instituted after systemic invasion. Salvarsan will clear

up symptoms much more rapidly than mercury. The chances for obtaining a negative Wassermann reaction in cases of latent lues even in very old cases are very good and they should be treated. All early cerebrospinal cases can be cured and a proportionately large number of old cases are favorable influenced by ordinary intravenous salvarsan and intramuscular mercury injections. The advantage claimed for intraspinal treatment does not seem to compensate for its disadvantage. A negative Wassermann reaction obtained after a single course of a few months of treatment does not indicate that a cure has been effected. A comparatively large proportion of patients returned to the positive Wassermann after a period of one year without treatment. Treatment therefore should be kept up for at least one year after the first negative result and if the Wassermann is still negative at that time, treatment may be discontinued and the patient watched.

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## PEDIATRICS

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UNDER THE CHARGE OF

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**Masked Juvenile Tuberculosis.**—COOKE and HEMPLEMANN (*Am. Rev. Tuberculosis*, November, 1920), in attempt to show that it is during childhood that infection with tuberculosis occurs, studied 1556 children by the complement-fixation test. The results in 116 who had manifest tuberculosis including chiefly pulmonary, meningcal and bone involvement with some cases of generalized infection, were interesting. The tests were uniformly negative in infants under one year of age, and was positive in only one-fifth of the cases between the first and second years. From the third to the sixth year the percentage of positive reactions rose to 50 and with each succeeding year it increased rapidly so that between nine and fifteen years of age 82 per cent of children with such active tuberculosis gave a positive complement-fixation test. Another group of 556 cases with no evidence of infection with tuberculosis and with negative skin tuberculin reactions gave only 19, or 3.4 per cent, positive reactions to the complement-fixation test. Only twenty well children were examined, who had been observed during an obviously active tuberculosis some years before. These children were free from all signs for from two to six years, and only two gave positive complement-fixation tests. These rather striking figures in themselves indicate that positive fixation tests accompany evidence of clinical activity in tuberculosis, and are found in relatively small proportions of children with such infections. In 131 cases of masked juvenile tuberculosis no case was seen under one year of age, and only five in the second year. After two years of age there was an increasing proportion of positive reactions to 50 per cent from the second to the fourth years and to 95 per cent for from the twelfth to the fifteenth year. In 116 children